UTAH DEPARTMENT OF HEALTH
TB Control/Refugee Health Program
TB SKIN TEST REPORT

Reporting Agency: _____ Contact Person: _____

Reporting Month: _____ Phone #: _____

Please fill in **monthly numbers** for each category

TB Testing Data

Total number of TB Skin Tests Administered	_____
Total Number of Converters*	_____
Number of TB Tests Positive	_____
Number receiving X-rays	_____

* A conversion is defined as an increase of $10 mm of induration within a 2-year period regardless of age

Reasons for Testing

Condition for Job/School	
Correctional Facility	
Refugee/Immigrant	
Homeless	
Substance Abuse	
Immunocompromised	
Migrant Farm Worker	
Missionary	

Age Breakdown

Age	Male	Female
0-14		
15-64		
65 >		
Total		

Ethnicity

Caucasian	
Asian	
Hispanic	
Native American	
African American	
Pacific Islander	

Send to: Utah Department of Health, TB Control and Refugee health Program, Box 142105, Salt Lake City, UT 84114-2105
Phone: (801) 538-9913 Fax: (801) 538-9913
This report is due by the 10th of each month

Form prepared in September 2002